

Manual Title	Chapter	Page
Personal/Respite Care Manual	App. C	
Chapter Subject	Page Revision Date	
Required Client Record Documentation	2-1-94	



APPENDIX C

REQUIRED CLIENT RECORD DOCUMENTATION

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APPENDIX C REQUIRED CLIENT RECORD DOCUMENTATION

Examples of the following documentation required for client records is included in this appendix:

- Long-Term Care Assessment Instrument (DMAS-95)
- Nursing Home Pre-Admission Screening Authorization (DMAS-96)
- Screening Team Plan of Care (DMAS-97 revised 11/93)
- Respite Care Needs Assessment and Plan of Care (DMAS-300)
- Provider Agency Plan of Care (DMAS-97A)
- Patient Pay Information (DMAS-122)
- Personal/Respite Care Aide Record (DMAS-90)
- Documentation of R.N. Supervisory Visit (DMAS-98)
- Recipient Progress Report (DMAS-99)
- HIV Waiver Services Pre-Screening Assessment (DMAS-113-A)
- HIV Waiver Services Pre-Screening Plan of Care (DMAS-113-B)
- Request For Supervision In Personal Care Plan Of Care

[illegible]

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DRESSING WITHOUT HELP 0 MH ONLY 1 HH ONLY 2 D MH AND HH 3 D IS DRESSED 4 D IS NOT DRESSED 5 D DESCRIBE HELP		MOBILITY LEVEL DATE <table border="1"><tr><td></td><td></td><td></td><td></td><td></td></tr></table> GOES OUTSIDE WITHOUT HELP 0 GOES OUTSIDE MH ONLY 1 d GOES OUTSIDE HH ONLY 2 D GOES OUTSIDE MH AND HH 3 D CONFINED MOVES ABOUT 4 D CONFINED—DOES 5 NOT MOVE ABOUT D DESCRIBE HELP											
TOILETING WITHOUT HELP 0 DAY & NIGHT MH ONLY 1 HH ONLY 2 D AND HH 3 D DOES NOT USE 4 TOILET ROOM D DESCRIBE HELP		EATING/FEEDING WITHOUT HELP 0 MH ONLY 1 HH ONLY 2 D MH AND HH 3 D SPOON FED 4 D SYRINGE OR TUBE FED 5 D FED BY IV OR CLYSIS 6 DO DESCRIBE HELP											
TRANSFERRING WITHOUT HELP 0 MH ONLY 1 HH ONLY 2 D MH AND HH 3 D IS TRANSFERRED 4 D IS NOT TRANSFERRED 5 D DESCRIBE HELP		BEHAVIOR PATTERN APPROPRIATE 0 I WANDERING/PASSIVE LESS THAN WEEKLY 1 I WANDERING/PASSIVE WEEKLY OR MORE 2 d ABUSIVE/AGGRESSIVE/DISRUPTIVE—LESS THAN WEEKLY 3 D ABUSIVE/AGGRESSIVE/DISRUPTIVE—WEEKLY OR MORE 4 DO COMATOSE 5 TYPE OF INAPPROPRIATE BEHAVIOR											
BOWEL FUNCTION CONTINENT 0 INCONTINENT 1 LESS THAN WEEKLY OSTOMY-SELF CARE 2 INCONTINENT 3 D WEEKLY OR MORE OSTOMY - NOT SELF CARE 4 D TYPE OF OSTOMY, OTHER PROBLEM 5		WHEELING DOES NOT WHEEL—MOVES ABOUT 0 WITHOUT HELP 1 MH ONLY 2 HH ONLY 3 MH AND HH 4 IS WHEELED 5 IS NOT WHEELED 6 DESCRIBE HELP											
		STAIRCLIMBING WITHOUT HELP 0 MH ONLY 1 HH ONLY 2 MH AND HH 3 DOES NOT CLIMB 4 DESCRIBE HELP											
		COMMUNICATION OF NEEDS VERBALLY-ENGLISH 0 VERBALLY—OTHER LANGUAGE 1 NONVERBALLY 2 DOES NOT COMMUNICATE 3 OTHER LANGUAGE, NONVERBAL COMMUNICATION											
		ORIENTATION ORIENTED 0 I DISORIENTED - SOME SPHERES SOME TIME d DISORIENTED - SOME SPHERES ALL TIME d DISORIENTED - ALL SPHERES SOME TIME D DISORIENTED - ALL SPHERES ALL TIME D COMATOSE 5 SPHERES AFFECTED											

SERVICES CURRENTLY RECEIVED				FILL IN SPACES AS INDICATED		NAME OR NUMBER	
THERAPIES				SPECIFY FREQUENCY		MEDICATIONS	
INHALATION 1	DATE	1, 4				SPECIFY EACH MEDICATION BY CATEGORY. INCLUDE DOSE ROUTE OF ADMINISTRATION 1, 7, FREQUENCY 1, 7 AND TIME OF LAST DOSE AT DISCHARGE. CHECK IF ADMINISTERED UNDER CORRESPONDING DATE.	
OCUPATIONAL 1						DATE	
PHYSICAL 1							
SPEECH 1							
REALITY/ REMOTIVATION 1							
SOCIAL SERVICE 1							
OTHER 1							
OTHER SERVICES/SOCIAL CONTACTS							
RECREATION/ ACTIVITIES 1							
RELIGIOUS SERVICES 1							
VISITORS 1							
OTHER 1							
NUTRITION							
DIET—SPECIFY 0, 8							
FOOD/FLUID (✓) INTAKE—NO PROB. 0							
PROBLEM— 1 SPECIFY							
SUPPLEMENTAL 1 NOURISHMENTS							
DINING LOCATION 0, 2							
SPECIAL NURSING PROCEDURES				SPECIFY SITES WHERE APPLICABLE TYPE AND FREQUENCY OF TREATMENT			
CUBITUS CARE 0, 1							
ESSING(S) 0, 1							
SITE(S) 1, 5							
EYE CARE— 1 SPECIFY							
OXYGEN Rx— 1, 4 TYPE:							
RESTORATIVE NURSING							
BOWEL 1 /BLADDER 2 TRAINING 3							
ROM EXERCISES SITES 1, 4							
OTHER 1							
RESTRAINTS—SITES OF APPLICATION 1							
TEACHING OSTOMY CARE— TYPE 1, 6							
SELF INJECTION 1, 4							
OTHER 1							
OTHER SPECIAL NURSING 1							
PROFESSIONAL VISITS				SPECIFY FREQUENCY OF VISITS			
ATTENDING MD/DO							
OTHER MD/DO							
AUDIOLOGIST							
DENTIST							
OPHTHALMOLOGIST/ OPTOMETRIST							
DIAETRIST							
HOME HEALTH							
OTHER							
						MEDICATION ADMINISTRATION	
						NO MEDICATIONS 0	
						SELF ADM. MONITORED LESS THAN WEEKLY 1	
						BY LAY PERSONS. MONITORED LESS THAN WEEKLY 2	
						BY LICENSED/PROF NURSE AND/OR MONITORED WEEKLY OR MORE 3	
						BY PROFESSIONAL NURSE 4	

TRANSLATION TO SERVICE NEEDS

1. RECORD THE DATE OF ASSESSMENT.
2. MATCH THE ASSESSED STATUS RECORDED AS 1, 2, OR 3 IN THE COMPLETED ASSESSMENT WITH THE SAME ITEMS IN THE ASSESSED STATUS COLUMN BELOW. CHECK THE SERVICE(S) NEXT TO EACH MATCHED ITEM UNDER THE DATE OF ASSESSMENT.
3. MATCH THE ASSESSED STATUS FOR BEHAVIOR PATTERN WITH THAT OF ORIENTATION AND CHECK THE CORRESPONDING SERVICE AS NEEDED. IF THE ASSESSED STATUS IS "1" FOR BEHAVIOR AND ORIENTATION, NO SERVICE IS CHECKED AS NEEDED.

NAME OR NUMBER

ADDITIONAL INFORMATION/PLAN

ASSESSED STATUS	DATE	SERVICE NEEDS 1		✓ OR SPECIFY, IF CHANGE OCCURS, RECORD DATE AND CHANGE		AT REASSESSMENT, DATE AND ✓ IF SERVICE RECEIVED 1
		SOCIAL SUPPORT 1	SERVICE PROVIDER			
NON-INSTITUTIONAL LIVING SPACE D Not Available		HOMEFINDING SERVICE				
SIGHT D IMPAIRMENT — NO (ATTEMPTED) COMPENSATION		OPHTHALMOLOGY/OPTOMETRY				
HEARING D IMPAIRMENT — NO (ATTEMPTED) COMPENSATION		AUDIOLOGY				
SPEECH D IMPAIRMENT SIX MONTHS AGO OR LESS — THERAPY NOT COMPLETED		SPEECH THERAPY				
DENTITION D SOME OR NO OPPOSING TEETH — NO COMPENSATION		DENTAL SERVICE				
FRACTURED HIP(S) DO ONE YEAR AGO OR LESS AND REHABILITATION NOT COMPLETED		PHYSICAL THERAPY				
PARALYSIS/PARESIS DO REHABILITATION NOT COMPLETED						
MISSING LIMBS D REHABILITATION NOT COMPLETED						
JOINT MOTION INSTABILITY UNCORRECTED OR IMMOBILITY D						
LIMITED MOTION d		PROFESSIONAL NURSING				
EATING/FEEDING DO FED BY I.V. OR CLYSIS						
MEDICATION ADMINISTRATION SOME OR ALL BY PROFESSIONAL NURSE D						
BY LICENSED OR PROFESSIONAL NURSE d		LICENSED OR PROFESSIONAL NURSING				
ACTIVITIES OF DAILY LIVING DRESSING TOILETING TRANSFERRING BOWEL FUNCTION BLADDER FUNCTION EATING/FEEDING	D FOR 5, 6, OR 7 ADL	MEAL PREPARATION				
	D FOR 2, 3, 4, 5, 6, OR 7 ADL	HOUSEKEEPING				
		ADL OR SUPERVISION BY LAY PERSONS OR AIDES				
BEHAVIOR PATTERN 1-APPROPRIATE OR WANDERING/PASSIVE LESS THAN WEEKLY 4-WANDERING/PASSIVE WEEKLY OR MORE	AND 6-DISORIENTED SOME SPHERES 1-ORIENTED					
1-APPROPRIATE OR WANDERING/PASSIVE LESS THAN WEEKLY 6-WANDERING/PASSIVE WEEKLY OR MORE	AND 2-DISORIENTED ALL SPHERES 4, 5-DISORIENTED SOME OR ALL SPHERES	EMOTIONAL AND SOCIAL ASSESSMENT SERVICES				
2-ABUSIVE/AGGRESSIVE DISRUPTIVE LESS THAN WEEKLY 5-ABUSIVE/AGGRESSIVE/ DISRUPTIVE WEEKLY OR MORE	AND 1-ORIENTED 4-OR 2-DISORIENTED 1-ORIENTED 4-OR 2-DISORIENTED	EMOTIONAL AND SOCIAL TREATMENT SERVICES				
MOBILITY LEVEL 4, D GOES OUTSIDE WITH HELP OR DOES NOT GO OUTSIDE		SHOPPING				
OTHER SERVICE NEEDS						

PREFERENCES ☐ NONE

ACTIVITIES/HOBBIES/
INTERESTS 2

OTHER 3

REASON FOR REFERRAL/DISCHARGE

IF DECEASED, CAUSE OF DEATH

HICDA CODE DATE

PHYSICIAN'S SIGNATURE

PHYSICIAN'S ORDERS FOR CARE

NAME OR
NUMBER

PHYSICIAN'S SIGNATURE

DATE

DATE OF
NEXT VISIT

I () CERTIFY () RECERTIFY THAT () SKILLED₁ () INTERMEDIATE₂ NURSING CARE () OTHER PROFESSIONAL₃ SERVICES ARE REQUIRED BY THE BENEFICIARY () ON AN IN-PATIENT BASIS OR () ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME, FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE () MEDICARE₁ () MEDICAID₂ REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY () ME OR () _____ AT LEAST EVERY _____ MONTHS.

PROGNOSIS/
REHABILITATION POTENTIAL

PHYSICIAN'S SIGNATURE

DATE

PHYSICIAN'S SIGNATURE

DATE

DATE OF
NEXT VISIT

I () CERTIFY () RECERTIFY THAT () SKILLED₁ () INTERMEDIATE₂ NURSING CARE () OTHER PROFESSIONAL₃ SERVICES ARE REQUIRED BY THE BENEFICIARY () ON AN IN-PATIENT BASIS OR () ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME, FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE () MEDICARE₁ () MEDICAID₂ REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY () ME OR () _____ AT LEAST EVERY _____ MONTHS.

PROGNOSIS/
REHABILITATION POTENTIAL

PHYSICIAN'S SIGNATURE

DATE

PHYSICIAN'S SIGNATURE

DATE

DATE OF
NEXT VISIT

I () CERTIFY () RECERTIFY THAT () SKILLED₁ () INTERMEDIATE₂ NURSING CARE () OTHER PROFESSIONAL₃ SERVICES ARE REQUIRED BY THE BENEFICIARY () ON AN IN-PATIENT BASIS OR () ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME, FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE () MEDICARE₁ () MEDICAID₂ REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY () ME OR () _____ AT LEAST EVERY _____ MONTHS.

PROGNOSIS/
REHABILITATION POTENTIAL

PHYSICIAN'S SIGNATURE

DATE

PHYSICIAN'S SIGNATURE

DATE

DATE OF
NEXT VISIT

I () CERTIFY () RECERTIFY THAT () SKILLED₁ () INTERMEDIATE₂ NURSING CARE () OTHER PROFESSIONAL₃ SERVICES ARE REQUIRED BY THE BENEFICIARY () ON AN IN-PATIENT BASIS OR () ON AN INTERMITTENT BASIS FOR A BENEFICIARY CONFINED TO THE HOME, FOR CONDITION(S) ELIGIBLE FOR PRESUMED COVERAGE AS DESIGNATED IN THE () MEDICARE₁ () MEDICAID₂ REGULATIONS. THE ABOVE PATIENT IS UNDER CARE AND AN ESTABLISHED PLAN OF CARE WILL BE REVIEWED BY () ME OR () _____ AT LEAST EVERY _____ MONTHS.

PROGNOSIS/
REHABILITATION POTENTIAL

PHYSICIAN'S SIGNATURE

DATE

ADDITIONAL COMMENTS/JUSTIFICATIONS/RECOMMENDATIONS/DECISIONS

<p>NATURE</p> <p>AFFILIATION</p>	<p>SIGNATURE</p> <p>AFFILIATION</p>	<p>SIGNATURE</p> <p>AFFILIATION</p>	<p>SIGNATURE</p> <p>AFFILIATION</p>
----------------------------------	-------------------------------------	-------------------------------------	-------------------------------------

NURSING HOME PRE-ADMISSION SCREENING AUTHORIZATION

Please provide the appropriate answer by either filling in the space or putting the correct number in the box provided.

Name: _____ Social Security Number: _____

Is Currently Medicaid Eligible? _____ Medicaid Number: _____

- If no Medicaid number now, is it anticipated that the individual will be financially Medicaid eligible within 180 days of nursing home? Yes = 2 No = 3 ☐

- Has individual formally applied for Medicaid? Yes = 1 No = 0 ☐

Dept. of Social Services _____
(Eligibility Responsibility) (Services Responsibility)

NURSING HOME APPLICATION

Has the Individual made formal application to a nursing home? ☐

- 1 = Yes _____
- 0 = No _____ (name of nursing home)
- 2 = Plans to apply
- 3 = Is currently a nursing home resident

MEDICAID AUTHORIZATION

- 1 = Nursing Facility ☐
- 3 = AIDS/ARC Services
- 4 = Personal Care
- 5 = Adult Day Health Care (ADHC)
- 6 = ADHC + Personal Care
- 7 = Respite Care
- 8 = Other Services Recommended
- 9 = Active Treatment for MI/MR Condition
- 0 = None

COMMUNITY-BASED CARE REFUSED

This section refers only to those individuals who were offered Community-Based Care and refused. ☐

- 1 = Patient/Family not interested
- 2 = Could not afford patient pay
- 3 = Other: _____
- 8 = Not Applicable

COMMUNITY-BASED CARE NOT OFFERED

This section is to be completed when Community Based Care is not offered. ☐

- 1 = Did not meet level of care criteria
- 2 = Appropriate Plan of Care could not be developed
- 3 = Plan of Care not cost effective
- 4 = No provider agency available
- 8 = Not Applicable

LEVEL II ASSESSMENT DETERMINATION

- 0 = Not referred for Level II assessment ☐
- 1 = Referred, Active Treatment needed
- 2 = Referred, Active Treatment not needed
- 3 = Referred, Active Treatment needed but individual chooses nursing home

LENGTH OF STAY (If approved for Nursing Home)

- 1 = Temporary (expected to return home in less than 3 months) ☐
- 2 = Temporary (expected to return home in less than 6 months)
- 3 = Continuing (more than 6 months)
- 8 = Not Applicable

SCREENING IDENTIFICATION

- Name of hospital and provider number: _____

- Name of health department/ASO and provider number: _____

- Social Service City/County Code: _____

- Name of Community Services Board and ID number: _____

- Did the individual expire after the Screening decision but before services were received? ☐

1 = Yes 0 = No

SCREENING CERTIFICATION

This authorization, and Community-Based Care Plan of Care, if Community-Based Care services are authorized, is appropriate to adequately meet the recipient's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ R.N., Date _____

_____ S.W., Date _____

_____ M.D., Date _____

SCREENING TEAM PLAN OF CARE FOR MEDICAID-FUNDED LONG TERM CARE

Individual Being Screened: _____ Medicaid ID # _____

SCREENING TEAM DETERMINATION: Refer to Appendix B, NHPAS manual

Individual Meets Nursing Facility Criteria (Functional Dependency Level and Medical/Nursing Need Present): _____
(Must be checked to authorize Nursing Facility Placement)

B. Individual Meets Pre-Nursing Facility Criteria: _____ (If "B" is checked, also check whether "1" or "2" is met)

1. Meets the Functional Dependency Component, But Lacks Medical/Nursing Need: _____
2. Rated Dependent in 4 ADL's & Mobility and Has Medical/Nursing Need: _____

Indicate Medical/Nursing Need: _____

C. Individual is At Risk of Nursing Facility Placement if Community-Based Care Is Not Offered: _____

☐ Application for the individual to a nursing facility has been made and accepted. Date application was made _____
Facility _____ Contact _____

☐ Deterioration in individual's health care condition or changes in available support prevents former care arrangements from meeting needs. Describe: _____

☐ Evidence is available that demonstrates person's medical and nursing needs are not being met (e.g. Recent hospitalization; doctor's documentation of instability, findings from medical/social service agencies). Describe: _____

Complete Section II ONLY if nursing facility or pre-nursing facility criteria and risk of Nursing Facility placement Are Met

II. COMMUNITY CARE CHOICE AND PAYMENT RESPONSIBILITY

Medicaid will pay for someone to come into your home to care for you as long as in-home care will safely meet your needs and will not be more expensive than nursing home care. You may choose to receive in-home services as long as there is an available provider in your area and either you have some additional support from family or friends or you are able to manage without additional help when the home care is not being provided. To stay at home, help in the following areas is needed: ☐ ADL's ☐ Housekeeping ☐ Meal Preparation ☐ Shopping

☐ Laundry ☐ Supervision ☐ Transportation ☐ Skilled Needs. Please identify any people or agencies that are able to provide you with

service, either on a regular basis or as needed:

Name/Agencies

What Areas of Help Will They Provide

Days & Hours/Week

I choose to receive the following community care instead of nursing home care:

☐ Personal Care Services requested _____ days/week. Special Needs (Check any required for the recipient's safe care):

____ Split Shift ____ hrs. in am ____ hrs. in pm ____ Supervision time is needed (Attach Supervision Request Form)

____ Special Maintenance Activities (e.g. bowel program, range of motion, routine wound care): Describe _____

____ Weekend Care is Necessary Due To: _____

☐ Adult Day Health Care Services requested _____ days/week from ____ a.m. to ____ p.m. Transportation is Needed: _____

____ (Provider Agency) has been chosen and contacted and is able to provide the care requested. I understand that the provider will develop with me a plan of care based on my needs and my available support. Provider staff are responsible to provide continuous, reliable care but, there may be an occasional lapse in service for which I will need to provide back-up support. I understand that, based on my income, I may have a co-pay of \$ _____ /month regardless of the amount of community care received.

Client Signature

Date

Screener Signature

Date

III. NURSING FACILITY CHOICE AND PAYMENT RESPONSIBILITY:

Community Care alternatives were explained completely but were not an option for me because _____

☐ I choose to receive nursing facility care and am requesting admission to _____ (facility)

I understand that I may have to pay \$ _____ /mo. in order to receive nursing facility care. Community/ in-home care has been

explained completely and I understand the options for care that are available? ☐ Yes ☐ No

Client Signature

Date

Screener Signature

Date

PATIENT INFORMATION

Medicaid ID: _____ Provider Name: _____
Recipient Name: _____ SSN: _____ DOB: _____
Address: _____

I. Provider Section

Payment Status (Complete Appropriate Blocks)

Report any admission, discharge, and/or change in patient status

Patient admitted to this facility/service on : _____ (date)

Level of care: ☐ Skilled ☐ Intermediate

Patient discharged or expired on _____ (date)

Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired

☐ Case in Need of Review/DMAS-122 requested

☐ Personal Funds Account balance \$ _____

☐ Patient's income or deductions have changed

☐ Other/explain: _____

Prepared by

Name: _____ Title: _____

Telephone: _____ Date: _____

II. DSS Section

Eligibility Information: (Check One)

☐ Is eligible for full Medicaid services beginning _____ (date)

☐ Is ineligible for Medicaid services

☐ Is eligible for QMB Medicaid only

☐ Is ineligible for Medicaid payment of LTC services from _____ to _____
due to transfer of assets

☐ Is eligible for Medicare premium payment only

☐ Has Medicare Part A Insurance

☐ Has other health insurance

III. Patient Pay Information

	MMYY	MMYY	MMYY
Patient Pay Amount	_____ _____	_____ _____	_____ _____

Comments: _____

Note: Medicaid Long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g. the SSA check received in January is used toward the cost of care in January.

Worker Name: _____

Agency Name: _____ FIPS Code: _____

Telephone: _____ Date: _____

PATIENT INFORMATION

Medicaid ID: _____ Provider Name: _____
Recipient Name: _____ SSN: _____ DOB: _____
Address: _____

I. Provider Section

Payment Status (Complete Appropriate Blocks)

Report any admission, discharge, and/or change in patient status

Patient admitted to this facility/service on: _____ (date)

Level of care: ☐ Skilled ☐ Intermediate

Patient discharged or expired on: _____ (date)

Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired

☐ Case in Need of Review/DMAS-122 requested

☐ Personal Funds Account balance \$ _____

☐ Patient's income or deductions have changed

☐ Other/explain: _____

Prepared by

Name: _____ Title: _____

Telephone: _____ Date: _____

II. DSS Section

Eligibility Information: (Check One)

☐ Is eligible for full Medicaid services beginning _____ (date)

☐ Is ineligible for Medicaid services

☐ Is eligible for QMB Medicaid only

☐ Is ineligible for Medicaid payment of LTC services from _____ to _____
due to transfer of assets

☐ Is eligible for Medicare premium payment only

☐ Has Medicare Part A Insurance

☐ Has other health insurance

III. Patient Pay Information

	MMYY	MMYY	MMYY
Patient Pay Amount	_____	_____	_____

Comments: _____

Note: Medicaid Long-term care providers cannot collect more than the Medicaid rate from the patient. Income is used for the cost of care in the month in which it is received, e.g. the SSA check received in January is used toward the cost of care in January.

Worker Name: _____

Agency Name: _____ FIPS Code: _____

Telephone: _____ Date: _____

PATIENT INFORMATION
FORM NUMBER DMAS-122

PURPOSE OF FORM—To allow the local DSS and the nursing facility or Medicaid Community-based Care provider to exchange information regarding:

1. The Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. A change in the patient's level of care;
4. Admission or discharge of a patient to an institution or Medicaid CBC services, or death of a patient;
5. Other information known to the provider that might cause a change in the eligibility status or patient pay amounts.

USE OF FORM—Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each nursing facility or CBC waiver patient at the time initial eligibility is determined or when a Medicaid enrolled recipient enters a nursing facility or CBC waiver services. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in a change in the amount of patient pay or the patient's eligibility status. The local DSS must send an updated form to the provider at least once a year, even if there is no change in patient pay.

The provider must use the form to show admission date, to request a Medicaid eligibility status, Medicaid recipient I.D., and patient pay amount; to notify the local DSS of changes in the patient's circumstances, discharge or death.

NUMBER OF COPIES—Original and one copy for nursing facility patients and original and two copies for CBC patients.

DISTRIBUTION OF COPIES—For nursing facility patients, send the original to the nursing facility and file the copy in the eligibility case folder. For Medicaid CBC patients, refer to section M1470.800 B.2. to determine where the original and any copies of forms are sent.

INSTRUCTIONS FOR PREPARATION OF THE FORM—Complete the heading with the name of the nursing facility or Medicaid CBC provider, the address, the patient's name, social security number, and Medicaid recipient I.D.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Eligibility information

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of coverage.
2. Check the second block if the individual is ineligible for payment of all Medicaid services.
3. Check the third block if the individual is eligible as QMB only (not dually eligible).
4. Check the fourth block if ineligible for Medicaid payment due to transfer of assets. Dates of disqualification must be listed on the form. Send copy to DMAS.
5. Check the fifth block if eligible for Medicare premium payment only.
6. Check the sixth block if the individual has Medicare Part A insurance.
7. Check the last block if the individual has other health insurance.

Patient Pay Information

Enter the month and year in which patient pay amount is effective. Enter the patient pay amount under the appropriate month and year.

PROVIDER AGENCY PLAN OF CARE

RECIPIENT NAME: _____ MEDICAID ID#: _____
 PROVIDER AGENCY: _____ AGENCY ID#: _____

EACH TASK TO BE DONE. ENTER TIME NEEDED FOR EACH CATEGORY AND ADD FOR TOTAL TIME

ORIES/TASKS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
DL's							
Bathing							
Dressing							
Toileting							
Transfer							
Grooming							
Assist Eating							
Assist Ambulate							
Turn/Change							
Position							
TIME							
2. SPECIAL MAINTENANCE							
Vital Signs							
Supervise Meds							
Range of Motion							
Wound Care							
Bowel/Bladder prog.							
TIME							
3. SUPERVISION							
TIME							
4. HOUSEKEEPING							
Prepare Meals							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used							
by Recipient							
Shop/List Supplies							
Laundry							
TIME							
TOTAL DAILY TIME							

COMPOSITE ADL SCORE = (SUM THE ADL RATINGS WHICH DESCRIBE THIS RECIPIENT)

BATHING SCORE		TRANSFERRING SCORE	
Bathes without help or w/MH only	0	Transfers without help/ w/MH only	0
Bathes w/ HH or w/ HH & MH.	1	Transfers w/ HH or w/ HH & MH	1
Is bathed	2	Is transferred/ does not transfer	2
DRESSING SCORE		EATING SCORE	
Dresses without help or w/MH only	0	Eats without help/ w/ MH only	0
Dresses w/ HH or w/ HH & MH	1	Eats w/ HH or HH & MH	1
Is dressed or does not dress	2	Is fed: spoon/tube/IV, etc.	2
AMBULATION SCORE		CONTINENCY SCORE	
Walks/Wheels without help/ w/MH only	0	Continent /incontinent < weekly	
Walks/Wheels w/ HH or HH & MH	1	/self care of internal/ external devices	0
Totally Dependent for mobility	2	Incontinent weekly or >/Not self care	2

LEVEL OF CARE (LOC) A (SCORE 0-6) B (SCORE 7-12) C (SCORE 9+ WOUNDS, TUBE FEEDINGS, ETC)
 THE AMOUNT OF TIME NEEDED TO COMPLETE ALL TASKS MUST NOT EXCEED THE MAXIMUM FOR SPECIFIED LOC
 LOC A= MAXIMUM HOURS 25/WK B= MAXIMUM HOURS 30/WK C= MAXIMUM HOURS 35/WK

REASON PLAN OF CARE SUBMITTED: NEW ADMISSION ↓ IN HOURS ↑ IN HOURS TRANSFER
 SON FOR CHANGE/ADDITIONAL INSTRUCTIONS FOR THE AIDE: _____

EFFECTIVE DATE OF THIS PLAN OF CARE _____ TOTAL WEEKLY HOURS _____ RN SIGNATURE _____
 IMAS-97A Rev. 7/90

AIDE RECORD

Recipient Name: _____ Address/Phone: _____

DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
DATE (Month/Day/Year)							
ACTIVITY:							
Complete/Partial Bath							
Dress/Undress							
Assist with Toileting							
Transferring							
Personal Grooming							
Assist with Eat-Feed							
Ambulation							
Turn/Change Position							
Vital Signs							
Assist with Self-Admin. Medication							
Special Task Authorized							
Supervision							
Prepare Breakfast							
Prepare Lunch							
Prepare Dinner							
Clean Kitchen							
Wash Dishes							
Make/Change Bed Linen							
Clean Areas Used by Recipient							
Listing Supplies/Shopping							
Recipient's Laundry							
TIME IN							
TIME OUT							
NUMBER OF HOURS							

WEEKLY COMMENTS: DATE:

WEEKLY SIGNATURES

Recipient/ Family Signature	Date	Aide Signature	Date
Substitute Aide	Date	RN Signature	Date

RESPITE CARE NEEDS ASSESSMENT AND PLAN OF CARE

A. NAME _____ MEDICAID NO. _____
PRIMARY CAREGIVER _____ RELATIONSHIP TO CLIENT _____

C. **STRESSORS:** Describe factors that create a need for Respite Care.

LACK OF ADDITIONAL SUPPORT _____

OTHER DEPENDENTS _____

24-HOUR SUPERVISION REQUIRED _____

ILLNESSES/LIMITATIONS _____

OTHER _____

D. AMOUNT AND TYPE OF RESPITE CARE NEEDED

REASON RESPITE CARE REQUESTED _____

____ ROUTINE HOURS PER DAY _____ DAYS NEEDED _____
____ EPISODIC HOURS PER DAY _____ SPECIFY DATES NEEDED _____

CARE MUST BE PROVIDED BY LPN ____ NO ____ YES Describe Skilled Needs _____

E. PATIENT PAY

PATIENT PAY INFORMATION OBTAINED FROM _____
Eligibility Worker's Name Phone Number

F. FREEDOM OF CHOICE

In accordance with the policies and procedures of the Department of Medical Assistance Services I have been informed by _____ Pre-Admission Screening
Name of City/County or Hospital
team of the Medicaid-funded, long-term care options available to me and I choose:

☐ Respite Care Service ☐ Nursing Home Placement

I have been given a choice of the available Respite Care Provider agencies and my choice is _____. I understand that only the amount of Respite Care authorized above can be offered. In order to receive Respite Care instead of nursing home care, I understand that the cost to Medicaid for Respite Care (and any additional Medicaid-funded Home and Community-Based Care services) must be equal to or less than the cost to Medicaid for nursing home care. The Pre-Admission Screening team has determined that the above Plan of Care is cost-effective, appropriate to meet my health and safety needs and necessary to avoid nursing home care.

PHYSICIAN SIGNATURE

DATE

RECIPIENT/FAMILY SIGNATURE DATE

RN/COORDINATOR DOCUMENTATION (PC, ADHC, RC)

FULL ASSESSMENT: (Initial & @ 6 mos.) _____ **ASSESSMENT UPDATE:** (Routine 30 day) _____
IF ASSESSMENT UPDATE, ITEMS 2, 3 and 8 NEED ONLY INCLUDE CHANGES.

CLIENT NAME: _____ **NAME OF AIDE PRESENT:** _____

IF INITIAL VISIT: POC & program policies reviewed with Aide and Client _____
Who will sign Aide Record/Daily Log _____

1. MEDICAL/NURSING NEEDS (NOTE M.D. VISITS, ETC.): _____

2. FUNCTIONAL STATUS: Describe according to type of assistance required.

Bathing _____

Dressing _____

Toileting _____

Transferring _____

Bowel _____

Bladder _____

Eating/Feeding _____

Behavior _____

Orientation _____

Mobility _____

Joint Motion _____

Medication Administration _____

3. ADEQUATE SUPPORT SYSTEM: YES _____ NO _____ Describe support given and note who is providing the support: Family, friends, community/social/health services. _____

4. DATES OF ANY LAPSE IN SERVICE (HOSPITALIZATION, ETC.): _____
REASON: _____

5. SPECIAL SERVICE NEEDS: Rehab. Progress Notes (ADHC). Describe Supervision, Bowel/Bladder Programs, ROM, Routine Wound Care, External Condom Catheter, if received. _____

6. PLAN OF CARE:

Reflects needs of client: _____ Yes _____ No

Copy kept in the home (PC/RC): _____ Yes _____ No

AIDE RECORD/DAILY LOG:

Reflects Plan of Care: _____ Yes _____ No

Reviewed by the RN/Coordinator: _____ Yes _____ No

Indicate follow-up taken: _____

7. MONTHLY CLIENT/FAMILY COMMENTS RE: SERVICES: _____

8. HEALTH/SAFETY/WELFARE ISSUES: Describe client's living conditions/any problems which may affect the client's ability to stay safely at home. Indicate action taken to address any problem noted. _____

NOTE: _____ **RN/COORDINATOR SIGNATURE:** _____
JMAS-98

COMMUNITY-BASED CARE RECIPIENT PROGRESS REPORT

I. FUNCTIONING STATUS: INDICATE THE USUAL FUNCTIONING IN EACH AREA USING DMAS DEFINITIONS

BATHING		DRESSING		TOILETING		TRANSFERRING		BOWEL FUNCTION		EATING/FEEDING	
WITHOUT HELP	0	WITHOUT HELP	0	WITHOUT HELP DAY AND NIGHT	0	WITHOUT HELP	0	CONTINENT	0	WITHOUT HELP	0
1		MH ONLY	1	MH ONLY	1	MH ONLY	1	INCONTINENT LESS THAN WEEKLY	1	MH ONLY	1
2		HH ONLY	2	HH ONLY	2	HH ONLY	2	OSTOMY SELF CARE	2	HH ONLY	2
3		MH & HH	3	MH & HH	3	MH AND HH	3	INCONTINENT WEEKLY OR MORE	3	MH AND HH	3
IS BATHED/ DOES NOT BATHE	4	IS DRESSED	4	DOES NOT USE TOILET ROOM	4	IS TRANSFERRED	4	OSTOMY NOT SELF CARE	4	FED BY OTHERS-SPOON FED /SYRINGE/TUBE FED	4
		IS NOT DRESSED	5			NOT TRANSFERRED	5				

BLADDER		BEHAVIOR		ORIENTATION		MOBILITY LEVEL		JOINT MOTION		MED ADMINISTRATION	
CONTINENT	0	APPROPRIATE	0	ORIENTED	0	GOES OUTSIDE WITHOUT HELP	0	WITHIN NORMAL LIMITS	0	NO MED'S	0
INCONTINENT LESS THAN WEEKLY	1	WANDERING /PASSIVE LESS THAN WEEKLY	1	DISORIENTED SOME SPHERES SOME TIME	1	GOES OUTSIDE MH ONLY	1	LIMITED MOTION	1	SELF ADM. MONITORED LESS THAN WEEKLY	1
EXTERNAL/INDWELL/ OSTOMY-SELF CARE	2	WANDERING/PASSIVE WEEKLY OR MORE	2	DISORIENTED SOME SPHERES ALL TIME	2	GOES OUTSIDE HH ONLY	2	INSTABILITY CORRECTED	2	BY LAY PERSONS MONITORED LESS THAN WEEKLY	2
INCONTINENT-WEEKLY OR MORE	3	ABUSIVE AGGRESSIVE DISRUPTIVE LESS THAN WEEKLY	3	DISORIENTED ALL SPHERES SOME TIME	3	GOES OUTSIDE MH & HH	3	INSTABILITY UNCORRECTED	3	BY NURSE AND/OR MONITORED WEEKLY OR MORE	3
EXTERNAL-NOT SELF CARE	4	ABUSIVE AGGRESSIVE DISRUPTIVE WEEKLY OR MORE	4	DISORIENTED ALL SPHERES ALL TIME	4	CONFINED MOVES ABOUT	4	IMMOBILITY	4	BY NURSE	4
INDWELL CATHETER NOT SELF CARE	5	COMATOSE	5	COMATOSE	5	CONFINED DOES NOT MOVE ABOUT	5				
OSTOMY NOT SELF CARE	6										

II. MEDICAL/NURSING NEEDS: DESCRIBE RECIPIENT'S CONDITION; WHY IT REQUIRES A PHYSICIAN/RN FAMILIAR & RESPONSIBLE FOR OVERSEEING CARE DAILY EITHER DIRECTLY OR INDIRECTLY THRU TRAINED NURSES AIDES WHO MONITOR THE CARE. INDICATE CURRENT, ACTIVE MEDICAL DIAGNOSIS, EVIDENCE OF MEDICAL INSTABILITY, NEED FOR OBSERVATION/ASSESSMENT TO PREVENT DESTABILIZATION, COMPLEXITY CREATED BY MULTIPLE INTERRELATED MEDICAL CONDITIONS, AND/OR ANY SPECIFIC NURSING/MEDICAL PROCEDURES.

CURRENT MEDICATIONS - INCLUDE DOSE, ROUTE OF ADMINISTRATION, FREQUENCY AND PURPOSE.

III. IS THIS RECIPIENT AT RISK OF NURSING FACILITY PLACEMENT IF CBC SERVICES ARE NOT RECEIVED?

YES ____ NO ____ PLEASE STATE WHY:

IV. PLAN OF CARE: # HOURS/DAY ____ # DAYS/PER WEEK ____ LEVEL OF CARE CATEGORY ____

SUPERVISION INCLUDED IN PLAN OF CARE? ____ YES ____ NO IF YES, ATTACH REQUEST FOR SUPERVISION FORM

IDENTIFY OTHER NON-MEDICAL COMMUNITY SERVICES CURRENTLY BEING PROVIDED. GIVE NAME OF PROVIDER, SERVICE PROVIDED & AMOUNT.

IDENTIFY ANY NEEDS OF THE RECIPIENT WHICH ARE NOT BEING MET. DESCRIBE EFFORTS TO ACCESS SERVICES TO MEET THESE NEEDS.

SUBMITTED BY (RN SUPERVISOR): _____ DATE _____

MEDICAID HIV WAIVER SERVICES PRE-SCREENING ASSESSMENT

Name: _____ Medicaid Number: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____ Ideal Weight: _____

Date of Assessment: _____ Assessor: _____ Screening Agency: _____

If no Medicaid number at present, has the person formally applied for Medicaid? ☐ No ☐ Yes, _____
(Date)

I. Stage of the Disease: Karnofsky Performance Status Scale Acuity Assessment (Circle rating in each area)

1. Nutrition

- A. Independent (fair knowledge base) 12
- B. Knowledge deficit/special diet 9
- C. Assist needed to prepare; nausea/vomiting; malnourished 7
- D. Artificial/alternative therapy 4

2. Hygiene

- A. Self Sufficient 11
- B. Needs Assist in preparation to dress independently 8
- C. Needs Help with bath and dressing 7
- D. Needs complete assist w/bath & dressing, unable to stand independently 4

3. Toileting

- A. Up to Bathroom Alone 11
- B. Needs bedpan or urinal 9
- C. Foley/external catheter. Assist to bathroom/BSC, incontinent 7
- D. Incontinent bowel and/or bladder Needs maximum assist 4

4. Activity

- A. Ad lib independently 11
- B. Ambulate or position w/minimal assist 8
- C. Maximum assist in ambulation or turning 8
- D. Bedridden 5

5. Behavior

- A. Alert and oriented 11
- B. Minimal Cognitive Impairment, cooperative, aware of place/time, communicates appropriately 8
- C. Occasionally listless, increased sleep or insomnia, verbally unresponsive 7
- D. Marked Dementia, responses minimal or absent 4

6. Teaching/Emotional Support

- A. Able to independently seek information & support 12
- B. Guidance needed in tapping resources
- C. Moderate time spent teaching and supporting 7
- D. Detailed in-depth teaching. Extensive time with patient & significant other. Possible communication barriers/sensory defects. Therapeutic sessions 4

7. Treatments/Medications

- A. Seeks information independently 12
- B. Instruction needed in care and meds Able to gain independence 9
- C. Care/surveillance/monitoring needed 7
- D. Frequent administration of meds and/or treatment. Maximum assist 5

INTERPRETATION

- Stage I** 71-100 Supportive/Educative: All actions performed to support or promote self care activity.
- Stage II** 51- 70 Partly compensatory: Actions performed to support patient until self-care activity is possible or performed with patient and significant other until significant other is able to complete care procedures.
- Stage III** 31- 50
- Early Chronic**
- Late Chronic**
- Stage IV** 0- 30 Wholly compensatory: Patient is completely dependent on nursing actions.
- Terminal**

TOTAL RATING _____
STAGE OF DISEASE _____

In order to refer for AIDS/HIV waiver services, patient must be Stage II - IV and be determined to require institutional services if AIDS/HIV waiver services are not offered.

I. Describe type of assistance needed; include frequency & average amount (i.e. good and bad days)

II. Medical Condition:

1. Attending Physician: _____ Address: _____
Phone # _____ Pharmacy: _____ Phone # _____

2. Primary Diagnosis: _____ Date of Onset _____

3. Other Diagnoses & Dates of Onset: _____

4. Check any of the following conditions affecting the diagnoses and necessitating requested services:
Wasting Syndrome _____ Dysphagia _____ Dementia _____ Debilitating weakness _____
Mental disorder _____ Decubitis _____ Pain _____ Skin Lesions _____
Other _____

5. Describe recent medical history, including frequency of Physician/Clinic/Hospital visits: _____

6. Lab Work: White Cell Count _____ CD-4 count _____ Percent _____ H/H _____
Serum Albumin _____ Other _____

7. Medications: Name	Frequency	Route of Administration	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

8. Nursing Care Needs: Check any that apply, note any others not indicated and provide any necessary description

IV, IM, SC injections daily _____	IV or Hyperal Therapy _____	NG, PEG, Gastrostomy feedings _____
Daily Sterile Dressing _____	Stage III or IV Decubitus _____	Skilled 24 hour nursing _____
Intermittent Injections _____	Oral, Topical, Instilled meds _____	Supervision of tube feeds, self care _____

✓. Nutritional Status: A complete nutritional assessment must be completed

Current GI Physiology:

- _____ Mouth lesions of more than 3 days duration, preventing chewing
- _____ Presence of esophageal ulcers
- _____ Difficulty swallowing
- _____ Vomiting, frequency _____
- _____ Diarrhea, frequency _____
- _____ Other specific enteropathy that requires modification: _____

Other Conditions affecting individual's eating patterns:

- _____ CNS infection
- _____ AIDS encephalitis
- _____ Impaired motor ability
- _____ Infection/febrile illness
- _____ Medication side effects
- _____ Emotional Stress

Weight Loss:

Nutritional Needs:

Ability to Prepare Own Meals?

_____ s to Others who can prepare meals?

✓. Psycho-Social Evaluation: Describe social support system, strengths/weaknesses, any additional stressors

SUMMARY: Provide a summary statement regarding whether this individual is at risk of institutional placement if HIV Waiver services are not offered. Statement must be supported by assessment information gathered.

MEDICAID HIV WAIVER SERVICES PRE-SCREENING PLAN OF CARE

Name: _____ Medicaid Number: _____

SERVICE NEEDS: Note services currently received & who is providing & services needed & potential provider

Service Area	Currently Received	Provider	Service Needed	Refer To Provider
Activities of Daily Living	_____	_____	_____	_____
Housekeeping	_____	_____	_____	_____
Living Space	_____	_____	_____	_____
Meals/Nutritional Supp.	_____	_____	_____	_____
Shopping/Laundry	_____	_____	_____	_____
Transportation	_____	_____	_____	_____
Supervision	_____	_____	_____	_____
Medicine Administration	_____	_____	_____	_____
Financial	_____	_____	_____	_____
Legal Services	_____	_____	_____	_____
Child Care	_____	_____	_____	_____
Foster Care	_____	_____	_____	_____
Dental	_____	_____	_____	_____
Counseling/Therapy	_____	_____	_____	_____
Substance Abuse Treatment	_____	_____	_____	_____
Health Education	_____	_____	_____	_____
Support Groups	_____	_____	_____	_____
Buddies/Companions	_____	_____	_____	_____
Home Health	_____	_____	_____	_____
Nursing	_____	_____	_____	_____
Patient Clinic	_____	_____	_____	_____
Equipment/Supplies	_____	_____	_____	_____
Physician	_____	_____	_____	_____
Hospice	_____	_____	_____	_____
Laboratory Services	_____	_____	_____	_____
Other	_____	_____	_____	_____

II. MEDICAID HIV WAIVER SERVICES: The following services are authorized to prevent institutionalization

CASE MANAGEMENT: _____ Provider: _____ Date Referred: _____

NUTRITIONAL SUPPLEMENTS: _____ Physician's Order Attached _____ Authorization Form to Recipient _____

PERSONAL CARE: _____ Provider: _____ Date Referred: _____

PRIVATE DUTY NURSING: _____ Provider: _____ Date Referred: _____

RESPIRE CARE: _____ Reason Requested: _____

Provider: _____ Type of Respite: _____ Aide _____ LPN _____ RN _____ Date Requested _____

I have been informed of the available choice of providers and have chosen the providers noted above:

Medicaid Recipient	Date	PAS Staff	Date
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MEDICAID HIV WAIVER SERVICES AUTHORIZATION FOR NUTRITIONAL SUPPLEMENTS

ATTENTION: Pharmacist

FROM:

RE:

Recipient Name

Name of Entity Authorizing Nutritional Supplements

Recipient's Medicaid ID #

Contact Person

Phone Number

The Department of Medical Assistance Services (DMAS) approves payment for nutritional supplements for qualifying individuals enrolled in the HIV Waiver Services Program. Effective, July 1993, the following entities may authorize DMAS payment for supplements: Nursing Home Preadmission Screening team members who are located in Local Health Departments and Social Service agencies; acute care hospital settings, infectious disease clinics and AIDS service organizations; DMAS staff; and AIDS Case Management providers. This form authorizes payment for nutritional supplements and you are authorized to begin dispensing them when you receive it for the individual named below.

SUPPLEMENT TYPE:

Supplement Name

Type

Quantity per day

AUTHORIZATION PERIOD:

From

(month/day/year)

Through

(month/day/year)

NOTE This authorization is valid for six (6) months, although you will only dispense a month's supply at a time. The recipient's nutritional needs will be reviewed and reauthorized every six (6) months by the Case Manager. This authorization is valid at the Medicaid provider of the recipient's choice. A new authorization form is required if supplements are required beyond this authorization period, any time the recipient wishes to change pharmacy, or the type or amount of supplement required changes. Any supplements dispensed not in accordance with this procedure will be rejected.

BILLING INSTRUCTIONS: Claims for Nutritional Supplements delivered through the HIV/AIDS waiver program have not been fully computer automated to date. All claims submitted for payment will pend for manual processing. We have not found this to delay payment as long as the instructions provided below are followed:

Providers Who Bill Using Magnetic tape billing: You must note your provider id# and pharmacy name below and send a copy of this authorization form to DMAS, Medical Support Section, Pharmacy unit, 600 E. Broad St., Richmond, VA 23219. This will assure prompt, accurate processing of your claim.

Provider ID #

Provider Name

Date

Providers Who Bill Using Manual billing: Make enough copies of this form to cover the authorization period. Attach a copy of this form to the Pharmacy invoice (DMAS 173) each time you submit a claim for payment.

If you have questions about the authorization, contact the authorizing agent listed above or the Pharmacy section at (804) 786-3820. You may contact the HELPLINE at (800) 552-8627 for questions related to Billing.

NUTRITIONAL ASSESSMENT

An individual may be at nutritional risk, if he or she has the following symptoms:

- 1) If a person weighs less than 90% of their USUAL BODY WEIGHT, i.e., has experienced significant or severe weight loss over the last 1-6 months (see weight status worksheet);
- 2) If a person has lost more than 5 lbs within the preceding month, i.e., rapid weight loss (again, see weight status worksheet),
- 3) If the serum albumin is less than 3.2 (or if the serum albumin is very high indicating dehydration),
- 4) If the person has difficulty chewing or swallowing,
- 5) If the person has persistent diarrhea.

IN WORKING WITH PEOPLE WITH HIV DISEASE, REMEMBER:

- work with USUAL or NORMAL BODY WEIGHT if you possibly can;
- AIDS elevates the basal metabolism, exacerbating weight loss.
- When a person has a fever, their metabolism is increased by 7% for every degree over 99 degrees.
- So someone with AIDS and an infection or fever of unknown origin (FUO) is at great risk for rapid weight loss.

RECOMMENDED AMOUNTS OF NUTRITIONAL SUPPLEMENTS:

- 3-4 cans/day if the person is still eating
- 8-10 cans/day if the person is relying on supplements for most nutrition

CAUTION:

- Many popular nutritional supplements are hypertonic (e.g., Ensure) which means that they may exacerbate the diarrhea and weight loss a person experiences.
- There are some nutritionals that are isotonic and preferable if a person has a problem with diarrhea (before or after supplementation).

WEIGHT STATUS WORKSHEET

NAME: _____

DATE: _____

Client's Height _____ Client's Weight _____
Usual Body Weight _____

Calculated Ideal Body Weight _____

Women: 105 lbs for the first 5',
plus 5 lbs for every inch over 5'.

Men: 106 lbs for the first 5',
plus 6 lbs for every inch over 5'.

WEIGHT Usual	WEIGHT Today	WEIGHT 1 month ago	WEIGHT 3 months ago	WEIGHT 6 months ago
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--	--	--	--	--

$$\text{PERCENT WEIGHT CHANGE} = \frac{(\text{Usual Weight} - \text{Actual Weight}) \times 100}{\text{Usual Weight}}$$

CALCULATED PERCENT WEIGHT CHANGE

over 6 months _____	Not Significant	Significant	Severe
over 3 months _____	Not Significant	Significant	Severe
over 1 month _____	Not Significant	Significant	Severe

TIME INTERVAL	SIGNIFICANT WEIGHT LOSS	SEVERE WEIGHT LOSS
1 WEEK	1-2 %	> 2%
1 MONTH	5.0%	> 5.0%
3 MONTHS	7.5%	> 7.5%
6 MONTHS	10.0%	> 10.0%

REQUEST FOR SUPERVISION IN PERSONAL CARE PLAN OF CARE

Recipient Name: _____ Medicaid Number: _____

Provider Name: _____ Provider Number: _____

I. RECIPIENT COGNITIVE AND PHYSICAL NEEDS WHICH CREATE NEED FOR SUPERVISION

A. Cognitive Impairment: Describe the recipient's level of confusion and impact it has on their behavior.

If confusion is greater at different times of the day, explain and state whether recipient cannot be left alone at all or the maximum amount of time the recipient can be left alone without a danger to self or others.

B. Physical Incapacity: Describe the degree of physical incapacity and how it creates a need for supervision or intermittent direct care by answering the following questions.

1. Incontinence:

Bowel _____ Frequency of Changes _____ Bladder _____ Frequency of Changes _____
Can Recipient Shift Position/Transfer Self without Assistance?

Skin Breakdown: Note Area Affected/Recent Documented Problems & Dates within Last Year

Potential for skin breakdown: Assess potential based on needed frequency of changes, ability to shift position, condition/history of skin integrity. Note whether the potential for skin breakdown is temporary or Expected to continue.

2. Falls: Describe any falls which have occurred during the past 3 months; Give dates, Activity being completed when the fall occurred; Time of day fall occurred, Possible role of medication (interactions, side effects), Interventions which have been attempted to reduce likelihood of falls (removing barriers, obtaining BSC, structuring activities when help is present), Recipient's use of judgement/denial of abilities.

3. Unstable Medical Condition: Describe recipient's needs in relation to an unstable medical condition.

List current diagnoses _____

Seizures: Note Frequency/Severity within the past 3 months.

Immobility: Discuss the degree to which the recipient is unable to ambulate due to the fact that any movement will exacerbate their medical condition or create risk of injury.

C. RECIPIENT'S ABILITY TO CALL FOR HELP:

Recipient Can Call For Assist _____ Yes _____ No, Reason:

II. Support System:

Primary Caretaker's Name _____ Home Phone # _____
Primary Caretaker Lives With Recipient? _____ If no, Address: _____
Primary Caretaker Works? _____ If yes, Work Place/Telephone#: _____
Work Hours: _____ Leaves home for work: _____ Returns from work _____

List Support/Back-Up for the Primary Caretaker when Personal Care Aide is not in the home: Include family/friends, other services received (e.g. Adult Day Care Program)

Discuss Whether Primary Caretaker Or Support Is Available During Times when Recipient would be alone and Could Respond to Recipient's Call For Assistance (i.e. could respond promptly if recipient fell, could come in to change recipient, etc) and whether this support is sufficient to meet the needs addressed in the previous section

III. ASSESSMENT OF RECIPIENT NEEDS

1. Recipient Cannot Be Left Alone At Anytime Without Presenting a Danger To Self: ____ Yes ____ No
2. Recipient Can Be Left Alone for Periods Up To _____, During These Times: _____

IV. PLAN OF CARE REQUIREMENTS TO PROVIDE NECESSARY SUPERVISION

Amount of Time in the Plan of Care for ADL care and Home Maintenance Requirements: _____

Amount of Additional Time Required for Supervision Which Cannot be Provided by Recipient's Support System

_____ Hours, Provided Between _____ and _____

Supervision Time Can be Obtained thru Provision of Services On a Split Shift Basis As Shown:

Personal Care Aides' work hours:

Monday-AM-Shift _____	PM-Shift _____	Thursday-AM _____	PM _____
Tuesday-AM _____	PM _____	Friday-AM _____	PM _____
Wednesday-AM _____	PM _____	Saturday-AM _____	PM _____
Sunday-AM _____		PM _____	

RN SUPERVISOR OR PAS TEAM MEMBER

AGENCY

DATE